Medical School Hotline

Teaching Geriatric Medicine to Family Practice Residents at the John A. Burns School of Medicine (JABSOM)

O. Pishchalenko, MD, PhD, N. Palafox MD, MPH, and P. Blanchette, MD, MPH
Departments of Geriatric Medicine and Family Practice
John A. Burns School of Medicine, University of Hawaii

The aging of the population brings new challenges to medicine. In the last century, the U.S. population 65 and older grew from 4% to 12%, and is projected to reach 20% by the year 2030. The American Association of Medical Colleges estimates that 75% of all current medical students, regardless of the specialty selected, will have a substantial number of older people in their practice. Because of the growing number of older people who have substantial responsibility for the care of children, even pediatricians will need to be keenly aware of common problems in older people to help prevent unintentional abuse and neglect. The challenge of providing knowledgeable health care to older people has generated an accreditation requirement to teach geriatrics to all medical students.

While Geriatric Medicine is a specialty, the majority of primary care for older people will continue to be provided by family practitioners and internists. This is ideal because of the benefits of longitudinal care provided by a physician who knows the patient and family well. When the care needs exceed those that can be provided in primary care, a referral to a geriatrician for evaluation or long-term follow-up is in order. Geriatricians usually practice as part of an established interdisciplinary team capable of handling complex, overlapping medical and psychosocial issues.

Family Practitioners may choose to provide geriatric care as a part of a mixed age practice or may become specialist geriatricians. The educational goals in geriatrics of a 3-year core family practice or internal medicine residency is for its trainees to attain a high standard of excellence in the primary care of older people and to recognize when referral is needed.

It has been recommended that at least 25% of the 3-year Family Practice residency consist of geriatrics training. Currently, every residency program is far from that goal. The reasons for the gap are several, including the shortage of both academic geriatricians and organized clinical teaching services in geriatrics. Training programs in family practice and internal medicine are required to have a formal curriculum and clinical experience in geriatrics. Family Practice was the first to make geriatrics an accreditation requirement. This requirement is usually interpreted and best met by having a formal required clinical rotation in geriatrics.

Physicians may enter fellowships in Geriatric Medicine after completion of residency program in either Internal Medicine or Family Practice. After successful completion of a one-year accredited clinical fellowship, and if board certified in either Internal Medicine or Family Practice, physicians are eligible to take the examination for certification in added qualifications (CAQ) in Geriatric Medicine. Specialty geriatricians often focus on consulting, medical education, research, long-term care, medical direction and program development. Because of the low reimbursement for each outpatient primary care visit and the extra time needed to see older people in the office, a fee-for-service primary care practice of Geriatric Medicine is rare. Currently there are only about 100 fellows graduating from Geriatric Medicine fellowships every year in the United States. Geriatric Medicine is considered a critical shortage specialty

A strong Geriatric Medicine curriculum is an important component of the JABSOM Family Practice residency program. The goals of the residency reflect an interest in developing family practice physicians for whom geriatrics will be an expanding part of their practice. In addition, the program assists the resident to improve their resident performance in geriatrics on both the Family Practice in-training examination and the American Board of Family Practice certifying examinations.

The Geriatric Medicine rotation in the Family Practice residency consists of a one-month block for third-year residents. Residents train at different sites, including, the Mililani Physician Clinic, Wahiawa General Hospital for acute care, the hospital's 100-bed Skilled Nursing Facility and Rehabilitation Center, home visits, and a network of community resources. Patients are first seen by residents who then present them to an attending and supervising physician assigned to help them formulate management plans.

The curriculum developed for the Family Practice residency consists of both didactic and clinical experiences throughout the 3 years of residency. This rotation for third-year residents provides both integrated and longitudinal training.

Integrated: The geriatrics curriculum is integrated into an existing structure so that all faculty will include relevant aspects of geriatric medicine into existing rotations. For example, during a general medical ward rotation, residents will explore geriatric topics, such as pharmacology in the elderly, functional assessment, the differentiation between dementia and delirium, and methods to limit the use of restraints and indwelling bladder catheters.

Longitudinal: Residents will care for a panel of patients for a 24-48 months period in a community and in an institutional setting. There will be a conference series where each presentation builds upon the knowledge base previously attained. Longitudinal experiences will allow residents to follow patients long enough to see the results of their medical decision.

Specific Clinical Experiences

Block rotation: Residents will focus exclusively on Geriatric Medicine for at least 1 month. This permits trainees to master a significant amount of material and apply it throughout the rest of their training program.

Multidisciplinary teams: Practitioners in other disciplines will contribute to the residents' knowledge about their patients. This will allow the residents to focus on clinical management, social and ethical problems, and functional issues.

Home visits: Residents will learn to assess and assist in keeping patients at home. In additon, they will also learn about the reasons for institutionalization and the current limitations of community-based home services. Finally, they will be able to examine the home environment and gather accurate nutritional and medication history. Home visits will be made to patients well known to residents, for example, people discharged from the resident's acute medical service or their continuity clinic.

Consultations: Prompt and effective consultations will help to build the geriatrics educational program by focusing on difficult management issues or complicated patients. Common consultation problems will include comprehensive assessments before a decision is made related to institutionalization, altered mental status, multiple medical problems, or preoperative assessments.

Nursing Facility: Although the majority of older people do not reside in nursing homes, those who do present challenging care problems. Residents will learn how to practice and understand the differences in management and regulations that govern their care in an acute hospital and a nursing facility. The nursing home experience is longitudinal, with a resident following four to eight patients over several years. The role of the medical staff and the regulations that govern medical care in a nursing facility will be covered both in the block rotation in geriatrics and in the longitudinal experience. Residents will participate in case conferences with the families and with the other professionals involved in the resident's plan of care.

Family Counseling: Family Practice deals with the care of the individual in the context of their family and social network. The intergenerational issues that form the background of a person's health and well-being are important to the understanding of the individual. Family issues in geriatrics are important as elders consider their historical and financial legacy, and contemplate the value of their lives in a social and spiritual context. Residents will learn to handle the family dynamics of emotionally charged issues such as moving to an assisted-living facility, moving in with relatives, permanent placement in institutional care, naming a designated surrogate or power of attorney, and making advance directives. Serious unresolved sibling rivalries may resurface when siblings become involved in decisions regarding their parents.

Compassionate caregiving: Patients suffer not only physically but also emotionally and spiritually. The need to provide both care and compassion is the underpinning of the educational goals.

The new geriatrics curriculum in the Family Practice Residency Program consists of a well-defined curriculum delivered through didactic and clinical experiences, case discussions, problem-solving conferences, discharge planning rounds, interdisciplinary care, and meetings with community agency staff, such as visiting nurses and community social workers. A strong training experience in geriatrics will help Family Practice residents provide overall primary care to older patients.

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